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MEMORANDUM

TO:

Legislative Oversight Committee Members	Commission for MH/DD/SAS
Local CFAC Chairs	State CFAC
NC Council of Community Programs	NC Assoc. of County Commissioners
County Managers	County Board Chairs
State Facility Directors	LME Directors
LME Board Chairs	DHHS Division Directors
Advocacy Organizations	Provider Organizations
MH/DD/SAS Stakeholder Organizations	NC Assoc. of County DSS Directors

FROM: Dr. Craigan L. Gray

Leza Wainwright

SUBJECT: Implementation Update #66

Application Process for IVC Designation	Medicaid Waiver Amendment Submission
Use of the Introductory PCP	CABHA Clarification
ValueOptions ProviderConnect Updates	Clarification on Procedures for Reviewing PA
Accreditation for Residential Service Providers	Requests & Obtaining Additional Information
Revised NEA Letter	Limits for Medicaid CM Services

Application Process for Designation of a Facility for the Custody and Treatment of Involuntary Clients

Facilities that serve or that intend to serve individuals under petitions of involuntary commitment must go through a review process in order to be authorized to accept and treat involuntary clients. Facilities currently serving involuntary clients that have not been through a review process for designation must do so in order to be in compliance with statute and rule. This includes community hospitals that have a contract with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the local management entity (LME) for the purchase of local inpatient psychiatric beds under Session Law 2008-107, Section 10.15.(k). This contract requires the capacity to serve individuals under an involuntary commitment order.

G.S. §122C-252 requires that designation of 24-hour facilities for the custody and treatment of involuntary clients be made in accordance with rules of the Secretary that assure protection of the client and the general public. 10A NCAC 26C .0100 establishes procedures by which DMH/DD/SAS reviews requests and designates facilities for the custody and treatment of involuntary clients for the following types of facilities:

- State facilities
- 24-hour facilities licensed in accordance with G.S. 122C:
  - 10A NCAC 27G .3100 Nonhospital Medical Detoxification for Individuals who are Substance Abusers
  - 10A NCAC 27G .5000 Facility Based Crisis for Individuals of all Disability Groups

- 10A NCAC 27G .6000 Inpatient Hospital Treatment for Individuals who have Mental Illness or Substance Abuse Disorders
- Hospitals licensed under G.S. 131E

Facilities must demonstrate both treatment capability and the ability to assure the safety of the client and the general public in order to be designated for the custody and treatment of involuntary clients.

Pursuant to Session Law 2005-371, DMH/DD/SAS maintains a list of facilities designated for the custody and treatment of involuntary clients. This central registry was established to assist law enforcement and others in locating facilities approved to treat individuals under a commitment order. Upon completion of the application process, facilities are placed on the registry. A link to this list can be found on the DMH/DD/SAS website at: http://www.ncdhhs.gov/mhddsas/.

To request designation of a facility for the custody and treatment of involuntary clients, the attached form with the requested information should be submitted to the DMH/DD/SAS Accountability Team's Policy Unit to the attention of Jamie Maginnes. Questions regarding the process should be directed to her at Jamie.Maginnes@dhhs.nc.gov.

Use of the Introductory Person Centered Plan (PCP)

This is a reminder to the provider community that the Introductory Person Centered Plan (PCP) can only be used and submitted to ValueOptions with an initial request if the consumer is brand new to the MH/DD/SA system or if the consumer has been completely discharged from services and has not received any MH/DD/SA services for 60 days or longer. This reminder is especially important to providers of services who have recently assumed responsibility for the development and implementation of the Person Centered Plan announced in Implementation Update #60:

- Child and Adolescent Day Treatment
- Psychosocial Rehabilitation
- Opioid Treatment
- SA Medically-Monitored Community Residential Treatment
- SA Non-Medical Community Residential Treatment
- Partial Hospitalization
- Residential II-IV (including Level II Family Type)

ValueOptions ProviderConnect Updates

Providers can now save an authorization request as a draft prior to online submission to ValueOptions via ProviderConnect. Partially or fully completed draft requests can be saved for up to seven days from the date originally saved. Providers can now save a draft request and return later to complete the draft and then submit. Also, providers have the option to perform a "second look" of a saved draft by a supervisor prior to online submission. This significant enhancement was developed in direct response to NC providers' feedback to ValueOptions.

Upon online submission of a service request, a provider can print the request itself, print confirmation of the submission, and/or download the request as a .pdf or .xml file to a computer; the last option being a recent enhancement to ProviderConnect.

Providers also can now submit requests for NC Health Choice consumers online via ProviderConnect in addition to Medicaid recipients. Remember, submit all requests for services under NC Health Choice with the child's NC Health Choice ID number and, conversely, Medicaid requests with the recipient's Medicaid ID.

Providers must participate in training before using ProviderConnect to submit service requests. Go to http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm and scroll down to "Provider Training Opportunities" to view the webinar schedule and register. It is not necessary for providers who previously completed webinar training to attend again, however they are welcome to participate to learn about new enhancements.

Accreditation for Residential Service Providers

As noted in Implementation Update #60 all Medicaid funded child mental health and substance abuse residential service providers (Level II-program type, III and IV) are required to be nationally accredited within one year of enactment of the S. L. 2009-451 for providers enrolled prior to August 7, 2009 or within one year of enrollment with the Division of Medical Assistance (DMA) for providers enrolled after August 7, 2009. That means that all child residential providers of Level II Program Type, Level III and Level IV services that were enrolled on August 7, 2009 must achieve national accreditation by August 7, 2010 (one year from date of enactment of the legislation). Accreditation benchmarks outlined in G. S. 122C-81 **will apply** to residential service providers. Information on how to apply the accreditation benchmarks can be found in Implementation Update #47 at: http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/dmadmh8-4-08update47.pdf.

Revised Notification of Endorsement Action (NEA) Letter

Attached is a revised Notification of Endorsement Action (NEA) letter. Please discontinue using the NEA letter form that is currently on the DMH/DD/SAS Endorsement website (dated 9/08) and implement the use of the attached letter effective January 11, 2010. This revised letter will be placed on the DMH/DD/SAS website. The revised letter includes more detailed information regarding reconsideration and appeals, national accreditation, and documentation requirements.

Medicaid Waiver Amendment Submission

The North Carolina Department of Health and Human Services (DHHS) announced in the December Medicaid Bulletin and in Communication Bulletin #106 that DHHS is requesting approval from the Centers for Medicare and Medicaid Services (CMS) for a mental health, developmental disabilities and substance abuse service waiver program.

The Waiver Technical Amendment was submitted to CMS on December 16, 2009. The model for this waiver amendment is based upon the current 1915 b/c waiver that has been operating in Cabarrus, Davidson, Rowan, Stanly, and Union counties since April 2005. The existing waiver is currently administered by the State through PBH (formerly known as Piedmont Behavioral Healthcare), a local management entity for the delivery of publicly funded mh/dd/sa services. PBH has been working in partnership with DMH/DD/SAS and DMA in support of this waiver expansion request to CMS.

DHHS is asking to replicate PBH's model with some additional amendments to the current 1915 b/c waiver application and make the waiver statewide with the ability to phase in new LME waiver entities. PBH as a waiver entity, starting as a pilot project, has demonstrated for the state the success of this model. Since 2005 DMA has contracted with Mercer to assist both Divisions in providing annual monitoring. Based upon the success of this model, DHHS wishes to expand the use of the waiver program.

Based upon CMS approval of the waiver expansion PBH will become part of the State's Waiver expansion. DMA and DMH/DD/SAS are currently contracting with Mercer to assist in the development of a Request for Applications (RFA) and selection criteria of local management entities who may be interested in becoming an LME waiver management entity.

DHHS plans to methodically select and add on additional LME wavier entities to operate in the same capacity as PBH as a prepaid health plan for the delivery of mh/dd/sa services. The tentative process and timeline for the Request for Application is as follows:

- Prepare and post RFA --- Target date: February 2010
- RFA applications due to DMA/DMH: April 2010
- Desk review and site review of RFA applicants: April - May 2010
- Announcement of selected LME waiver entity(ies): July 2010
- Waiver start date: July 2010 or dependent of several factors:
    - Dependent upon CMS approval of submitted Waiver Application Amendment
    - Approval of a New Technical Amendment to bring on the new geographical region of the LME waiver entity approved by CMS.
    - Transitional timeline of the new LME waiver entity timeline to begin full waiver operation activities.

DHHS will select one or two LME waiver entities to begin operation during SFY 2010/2011 if approved by CMS. An official announcement will be made concerning sites selected to participate in the program. DHHS will issue additional RFAs in the future to establish more LME waiver entities across the state based on the success of waiver programs.

DHHS is planning specific ways for consumers, family members and the general public to participate in the development, implementation and oversight of this project. Additional information about this 1915 b/c waiver will be provided through designated DMA and DMH/DD/SAS waiver web pages, the joint Implementation Updates, DMA Medicaid Bulletins and a special series of waiver Fact Sheets over the course of implementing this project.

Critical Access Behavioral Health Care Agency (CABHA) Clarification

We continue to receive questions related to the qualifications of the physician (MD/DO - Doctor of Osteopathy) who can serve as a medical director. The qualifications of the medical director are a psychiatrist (Board Eligible /Board Certified) or a physician with ASAM certification if the CABHA will have substance abuse as a primary focus of treatment.

We also continue to get questions regarding the minimum of two enhanced services that must be provided in addition to the core services. The list of additional services is defined in Implementation Update #63 and #64; however, in order to provide a continuum of service for the population to be served the services are required to be specific to the same age and disability type. The goal is for the core and additional services to create a continuum of services. An example is a provider who serves children with mental health issues might offer outpatient therapy, case management, intensive in-home and day treatment. If serving adults with mental health issues, the provider might offer outpatient therapy, psychosocial

rehabilitation, and community support team. The array will vary depending upon the age and needs of the consumers to be served by the agency.

Clarification on Procedures for Reviewing Prior Approval Requests and for Obtaining Additional Information

In an effort to improve the recipient due process procedure, DMA periodically publishes information to clarify or emphasize procedures related to due process. This article provides information about how the N.C. Medicaid Program and its vendors (such as ValueOptions, MedSolutions, CCME, HP Enterprise Services, etc.) review a prior approval request and how additional information about a prior approval request is obtained from the submitting provider or recipient.

Reviewing a Prior Approval Request

When a request is submitted to DMA or one of its vendors, it is reviewed to determine if it is a proper request. If the request is found to be improper, it cannot be processed by DMA or the vendor and it is returned to the sender. A proper request must include the information specified below. Additionally, a request may be returned to the provider as unable to process when another provider other than the requesting provider is currently authorized to provide the requested service. There are no written notice or appeal rights when a request is returned due to unable to process.

A proper request must include the following information:

- Recipient's name, Medicaid identification number (MID), date of birth
- Provider contact information, including signatures
- Date of request
- Service requested
- The required service order, if applicable
- Completed checkboxes that designate whether or not the clinician completed a face-to-face interview and reviewed the assessment (required for behavioral health prior approval requests)

When it is determined that a request is proper, it is reviewed by DMA or one of its vendors, as appropriate. The only actions that DMA or the vendor can take are to approve, deny, reduce, or terminate. In the past, if the provider submitted a request for a service that was not clinically indicated for the recipient, DMA or vendor staff shared with the provider the reasons why the request was not appropriate and suggested alternative services. The provider was allowed to change or withdraw the request. Medicaid has determined that this is a practice that should be changed to ensure that the recipient is involved in the decision to change or withdraw the request. Therefore, providers will no longer be able to change or withdraw the request once it has been submitted. The request will be considered as presented. As a result, it is imperative that the request contain all **recipient-specific** current clinical information that documents events, impairments, symptoms, and patterns that support satisfaction of the clinical coverage criteria for the requested service. If DMA or the vendor denies, reduces, or terminates, written notice with appeal rights will be issued to the recipient or the legal representative.

DMA and its vendors will continue to discuss and educate providers about alternative services that may be more appropriate clinically as well as to discuss/educate the provider about the policy. This discussion should not be construed as an attempt to have the provider change or withdraw the prior approval request. It is an effort to provide educational/collegial information to the provider.

Requesting Additional Information

From time to time, a provider may submit a request without sufficient information for DMA or the vendor to make a decision on the request. Medicaid's policy is that DMA or the vendor must request the specific information needed in writing. The provider must respond to this request by submitting the needed information or requesting a time extension within 15 business days of the date of the notice. If the provider does not submit the information or request a time extension, the request is denied, and a written notice with appeal rights is generated. Even if the recipient files an appeal, a new request with the needed information may be submitted at any time.

From time to time, information may be needed emergently or to clarify the request. It is acceptable for DMA or the vendor to contact the provider or the recipient by telephone to request the needed information. During the course of the conversation, DMA or the vendor will read a prepared statement indicating the purpose of the call and that the intent of the call is not to ask the provider or recipient to change or withdraw the request.

If you have questions about these procedures, please contact the Medicaid Appeals Unit at 919-855-4260.

Limits for Medicaid Case Management Services

Beginning March 1, 2010, there will be a monthly limit on the number of hours allowed for case management service. Providers will be paid for a maximum of three hours of case management each month.

These case management limits apply to CAP/C, CAP/DA, CAP/MR-DD, Targeted Case Management for Persons with Developmental Disabilities, and Early Intervention. Case management limits for the following programs remain unchanged: At Risk, Maternity Child Coordination, Child Service Coordination, Maternity Outreach, and HIV.

These limits may not apply to recipients under the age of 21 years as long as all criteria for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Medicaid for Children, are met. For further information about EPSDT, visit DMA's EPSDT web page.

Additional information and instructions will be published in the February 2009 Medicaid Bulletin.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@dhhs.nc.gov.

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